SERFF Tracking Number:	*AMLC-126243125*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*43096*
Company Tracking Number:	*LABR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Terminal Illness Accelerated Benefit Rider*		
Project Name/Number:	*Terminal Illness Accelerated Benefit Rider/LABR*		

Filing at a Glance

Company: Liberty National Life Insurance Company

Product Name: Terminal Illness Accelerated Benefit Rider	SERFF Tr Num: AMLC-126243125	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 43096
Sub-TOI: L08.000 Life - Other	Co Tr Num: LABR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Linda Newell	Disposition Date: 08/03/2009
	Date Submitted: 07/31/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Terminal Illness Accelerated Benefit Rider	Status of Filing in Domicile: Pending
Project Number: LABR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/03/2009	Explanation for Other Group Market Type:
	State Status Changed: 08/03/2009
Deemer Date:	Created By: Linda Newell
Submitted By: Linda Newell	Corresponding Filing Tracking Number: LABR

Filing Description:

We are submitting our Terminal Illness Accelerated Benefit Rider form LABR and Terminal Illness Accelerated Benefit Endorsement form LABRE for your review and approval. They are being submitted as a new filing for general use with our life portfolio.

This rider does not contain any unusual or unorthodox provisions or wording.

There is no additional premium charge for the LABR. This rider will not appear on any application as it cannot be applied for. This rider will be included automatically on new issues of standard issued life products. This rider will never

be added after a policy is issued.

There is no administrative fee charged if the insured selects to receive the accelerated benefit. This rider states that its value will be equal to 50% of the death benefit and that the death benefit is reduced by 50% upon payment of the accelerated benefit. The remainder of the death benefit is paid upon the death of the insured. Therefore, the benefits provided under this rider are financed in the same manner that the normal death benefit is financed.

The Terminal Illness Accelerated Benefit Disclosure and Acknowledgement form LABRD1 and Preliminary Terminal Illness Accelerated Benefit Payment Disclosure form LABRD2 are attached under the Supporting Documentation tab for your reference.

As further explanation of our procedures concerning these forms:

If an applicant applies for a policy to which this rider is attached, the agent would supply the LABRD1 disclosure which the applicant and agent would both sign. The applicant would keep a copy and a copy would be submitted to the company with the application.

Should the insured be diagnosed with a terminal illness from which a physician certifies the likelihood of the insured dying within one year, upon receiving a written request and proof of terminal illness, the Company would send the LABRD2 disclosure to the insured to provide the insured information as to the effect of such election to receive an accelerated benefit would have upon the policy benefits.

If the insured decided to receive an accelerated benefit after he reviewed the disclosure, the benefit would be paid and a new specification page would be created evidencing the new contract values. The LABRE endorsement would be sent to the insured along with the new specification page, advising the insured to keep the endorsement and new specification page with his policy. The remainder of the policy benefits would be paid upon the death of the insured.

Company and Contact

Filing Contact Information

Linda Newell, Compliance Analyst
3700 S. Stonebridge Drive
McKinney, TX 75070

lnewell@torchmarkcorp.com
214-544-5379 [Phone]
972-569-3728 [FAX]

Filing Company Information

Liberty National Life Insurance Company
2001 Third Avenue South
Birmingham, AL 35233
(800) 288-2722 ext. 2912[Phone]

CoCode: 65331
Group Code: 290
Group Name: Liberty National Life
FEIN Number: 63-0124600

State of Domicile: Nebraska
Company Type: Life and Health
State ID Number:

SERFF Tracking Number:	*AMLC-126243125*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*43096*
Company Tracking Number:	*LABR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Terminal Illness Accelerated Benefit Rider*		
Project Name/Number:	*Terminal Illness Accelerated Benefit Rider/LABR*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	Two forms at $20.00 each.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty National Life Insurance Company	$40.00	07/31/2009	29567914

SERFF Tracking Number:	*AMLC-126243125*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*43096*
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Product Name:	*Terminal Illness Accelerated Benefit Rider*		
Project Name/Number:	*Terminal Illness Accelerated Benefit Rider/LABR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/03/2009	08/03/2009

SERFF Tracking Number:	*AMLC-126243125*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*43096*
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Product Name:	*Terminal Illness Accelerated Benefit Rider*		
Project Name/Number:	*Terminal Illness Accelerated Benefit Rider/LABR*		

Disposition

Disposition Date: 08/03/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMLC-126243125*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*43096*
Company Tracking Number:	*LABR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
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Project Name/Number:	*Terminal Illness Accelerated Benefit Rider/LABR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	LABRD1 Disclosure and Acknowledgement		Yes
Supporting Document	LABRD2 Preliminary Disclosure		Yes
Supporting Document	Actuarial Memorandum		No
Form	Terminal Illness Accelerated Benefit Rider		Yes
Form	Terminal Illness Accelerated Benefit Endorsement		Yes

SERFF Tracking Number:	*AMLC-126243125*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*43096*
Company Tracking Number:	*LABR*		
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Product Name:	*Terminal Illness Accelerated Benefit Rider*		
Project Name/Number:	*Terminal Illness Accelerated Benefit Rider/LABR*		

Form Schedule

Lead Form Number: LABR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LABR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Terminal Illness Accelerated Benefit Rider	Initial		62.000	LABR.pdf
	LABRE	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Terminal Illness Accelerated Benefit Endorsement	Initial		0.000	LABRE.pdf

LIBERTY NATIONAL LIFE INSURANCE COMPANY

P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085
A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

TERMINAL ILLNESS ACCELERATED BENEFIT RIDER

forming a part of any Policy to which it is attached

INSURED: **[JOHN DOE]**
POLICY NO: **[SPECIMEN]**
DATE OF ISSUE: **[SEPTEMBER 9, 2009]**

Effective the date shown above, we have issued this Rider on your Policy. Any benefits under this Rider are subject to the provisions of this Rider and the Policy. In case of conflict between this Rider and the Policy, the provisions of this Rider will control. We will pay the Accelerated Benefit provided by this Rider to the Insured of the Policy. The benefit will be paid if the Insured has a Terminal Illness, subject to the provisions of this Rider, and upon receiving due proof.

ANY ACCELERATED BENEFIT PAID UNDER THIS RIDER MAY BE TAXABLE. A PERSONAL TAX ADVISOR SHOULD BE CONSULTED.

INSURED - "Insured" as used in this Rider means the Insured named above.

TERMINAL ILLNESS - The Insured has been diagnosed to have a noncorrectable medical condition that with reasonable medical certainty, will result in the death of the Insured within twelve (12) months from the date on which this benefit is requested. We will require written certification of the diagnosis of this Terminal Illness from the Insured's personal physician. We reserve the right to obtain a second medical opinion. Should the physician we choose disagree with the Insured's physician, we reserve the right to rely solely on our physician's opinion for claim purposes.

ACCELERATED BENEFIT - We will pay the Accelerated Benefit upon receiving due proof that the Insured has a Terminal Illness if:

1. **The Terminal Illness results from an injury which occurs on or after the Date of Issue or from a sickness which first manifests itself on or after 30 days from the Date of Issue; and**
2. **The Policy is in force at the time of such occurrence, except we will not pay the Accelerated Benefit if the Policy is in force under the Extended Term Insurance or Reduced Paid-Up Insurance Nonforfeiture Options.**

There is no administrative fee or charge associated with the election to receive the Accelerated Benefit.

AMOUNT OF BENEFIT - The amount of the Accelerated Benefit will be based on the Death Benefit of the Policy as of the date the Accelerated Benefit is paid. The amount of the Accelerated Benefit will be equal to:

1. **Fifty percent (50%) of the Death Benefit; less**
2. **Fifty percent (50%) of any outstanding Policy loan and loan interest; less**
3. **The overdue premium if a claim occurs during the grace period of an unpaid premium.**

The Accelerated Benefit provided is payable only once regardless of the subsequent occurrence of the same or a different condition which would otherwise be covered. No Accelerated Benefit will be provided if the Terminal Illness results from or is contributed by self-inflicted injuries, alcoholism, alcohol abuse, drug dependency or drug abuse.

EFFECT ON POLICY BENEFITS - On the date the Accelerated Benefit is paid, the Death Benefit will be reduced by fifty percent (50%) of the Death Benefit immediately prior to the payment of the Accelerated Benefit. The cash value and the policy loan and loan interest will also be reduced by fifty percent (50%) of their respective amounts immediately prior to the payment of the Accelerated Benefit.

PAYMENT OF BENEFITS - The Accelerated Benefit will be paid to the Insured unless instructed otherwise. Such instruction must be in writing to us and signed by the Insured. We must receive written consent for the payment of the Accelerated Benefit from all irrevocable beneficiaries, if any. We also reserve the right to require the written consent of any other person who may have a claim to policy benefits.

The Accelerated Benefit will be paid in one sum at our Administrative Offices in McKinney, Texas. So far as the law allows, no payment of benefits that we make will be subject to the claims of creditors.

INCONTESTABILITY - We will not contest this Rider after it has been in force during the lifetime of the Insured for two years from the Date of Issue, except for nonpayment of premium.

APPLICABILITY TO BASE POLICY ONLY - Amounts referred to in this Rider apply to the base Policy and do not include amounts for any other attached Rider, which includes, but is not limited to, Child Term Rider, Waiver of Premium Rider, Accidental Death Benefit Rider, etc. This Rider is only available to the Insured who qualifies as a standard risk pursuant the underwriting guidelines of the Company.

Signed for Liberty National Life Insurance Company at McKinney, Texas.

Secretary

President

LIBERTY NATIONAL LIFE INSURANCE COMPANY

P. O. BOX 8080, MCKINNEY, TEXAS 75070 * (972) 529-5085
A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

TERMINAL ILLNESS
ACCELERATED BENEFIT ENDORSEMENT

Effective date of changes: [12/18/09]

Payment has been made under the Terminal Illness Accelerated Benefit Rider on the contract shown below. The attached revised Specifications pages amend those in your contract. These revised pages reflect all changes to the contract values resulting from the payment of the Accelerated Benefit.

Policy Number: [SPECIMEN]

Insured: [JOHN DOE]

Please keep this endorsement with your contract.

Signed for Liberty National Life Insurance Company at McKinney, Texas.

Secretary

President

SERFF Tracking Number:	*AMLC-126243125*	*State:*	*Arkansas*
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Product Name:	*Terminal Illness Accelerated Benefit Rider*		
Project Name/Number:	*Terminal Illness Accelerated Benefit Rider/LABR*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Flesch.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
This requirement may not be applicable because this rider cannot be purchased via an application. This rider will automaticallybe attached to any approved life policy at no cost to the insured. Currently, the previously approved life policies to which this rider may be attached are offered via the attached applications:

LUNIV(03), SERFF Tracking Number AMLC-126096328, approved 5/15/09
LMGAPB(03), SERFF Tracking Number AMLC-126162719, approved 7/23/09
Attachments:
LUNIV(03).pdf
LMGAPB(03).pdf

Item Status: **Status Date:**

Satisfied - Item: LABRD1 Disclosure and Acknowledgement
Comments:
Attachment:
LABRD1.pdf

Item Status: **Status Date:**

Satisfied - Item: LABRD2 Preliminary Disclosure
Comments:

SERFF Tracking Number:	*AMLC-126243125*	*State:*	*Arkansas*
Filing Company:	*Liberty National Life Insurance Company*	*State Tracking Number:*	*43096*
Company Tracking Number:	*LABR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Terminal Illness Accelerated Benefit Rider*		
Project Name/Number:	*Terminal Illness Accelerated Benefit Rider/LABR*		

Attachment:

LABRD2.pdf

ARKANSAS

CERTIFICATION

This is to certify that the attached Policy Form LABR has achieved a Flesch Reading Ease Score of 62 and complies with the requirements of Arkansas Stat. Ann. SS66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Michael J. Gaisbauer, Vice President

SUPPLEMENTAL FORMS	SCORE

FORM S-1351(3) 5/82

APPLICATION FOR INSURANCE * LIBERTY NATIONAL LIFE INSURANCE COMPANY
A LEGAL RESERVE STOCK CO. * ADMINISTRATIVE OFFICE: MCKINNEY, TX

ARKANSAS/LOUISIANA

Requested Effective Date (mm-dd-yyyy)

[ ][ ] - [ ][ ] - [2][0][ ][ ]

Payment Mode ○ Monthly ○ Semi-Annual ○ Quarterly ○ Annual

Payment Type ○ Bank Draft ○ Direct Bill

Draft Day (01 to 28 only) [ ][ ]

BASE POLICY

○ Proposed Insured ○ Spouse ○ Child 1 ○ Child 2 ○ Child 3 ○ Child 4 ○ Child 5 ○ Child 6 ○ Child 7 ○ Child 8

IF YOU FAIL TO CHOOSE A DEDUCTIBLE OR MAXIMUM BENEFIT AMOUNT, IT WILL AUTOMATICALLY DEFAULT TO LOWEST AMOUNT.

	○ LIBERTY	○ INDEPENDENCE	○ FREEDOM			
DAILY HOSPITAL ROOM AND BOARD BENEFIT			**○ OPTION 1**	**○ OPTION 2**	**○ OPTION 3**	**○ OPTION 4**
	N/A	N/A	○ $100 ○ $300 ○ $200 ○ $400	○ $100 ○ $300 ○ $200 ○ $400	○ $400 ○ $600 ○ $500 ○ $700	○ $600 ○ $900 ○ $700 ○ $1,000 ○ $800
MISCELLANEOUS HOSPITAL EXPENSE BENEFIT						
	N/A	N/A	Deductible $250 / Maximum $2,500	Choose Deductible: ○ $ 500 ○ $1,000 ○ $2,500 / Choose Maximum: ○ $ 7,500 ○ $15,000	Choose Deductible: ○ $ 500 ○ $1,000 ○ $2,500 / Choose Maximum: ○ $15,000 ○ $25,000	Choose Deductible: ○ $ 500 ○ $1,000 ○ $2,500 ○ $5,000 / Choose Maximum: ○ $25,000 ○ $35,000 ○ $50,000 *(Only with $50,000 Max)*
SURGICAL PROCEDURE BENEFIT MAXIMUM						
	○ $700 ○ $2,100 ○ $1,400	$3,000	$1,500	○ $3,000 ○ $5,000	○ $5,000 ○ $7,500	○ $7,500 ○ $10,000
OUTPATIENT EXPENSE BENEFIT						
	$50	$250	$50	○ $250 ○ $500	○ $500 ○ $1,000 ○ $750	○ $1,000 ○ $1,500 ○ $1,250
DOCTOR OFFICE VISIT BENEFIT *(Per Visit)*						
	N/A	$25 *($250 Annual Max)*	$25 *($250 Annual Max)*	○ $25 *($250 Annual Max)* ○ $50 *($500 Annual Max)*	○ $50 *($500 Annual Max)* ○ $75 *($750 Annual Max)* ○ $35 Copay *($500 Annual Max)*	○ $75 *($750 Annual Max)* ○ $35 Copay *($500 Annual Max)* ○ $35 Copay *($1,000 Annual Max)*

Premium $ [ ][ ], [ ][ ][ ]. [ ][ ]

○ Additional Premium Required

OPTIONAL RIDERS

CANCER BENEFIT

○ Proposed Insured ○ Spouse ○ Child 1 ○ Child 2 ○ Child 3 ○ Child 4 ○ Child 5 ○ Child 6 ○ Child 7 ○ Child 8

○ **$10,000** ○ **$30,000** ○ **$20,000** ○ **$50,000**

Premium $ [ ], [ ][ ][ ]. [ ][ ]

CRITICAL ILLNESS BENEFIT

○ Proposed Insured ○ Spouse

○ **$10,000** ○ **$30,000** ○ **$20,000** ○ **$50,000**

Premium $ [ ], [ ][ ][ ]. [ ][ ]

ACCIDENT BENEFIT

○ Proposed Insured ○ Spouse ○ Child 1 ○ Child 2 ○ Child 3 ○ Child 4 ○ Child 5 ○ Child 6 ○ Child 7 ○ Child 8

○ **$10,000** ○ **$30,000** ○ **$20,000**

Premium $ [ ], [ ][ ][ ]. [ ][ ]

INCREASING BENEFIT

○ Proposed Insured ○ Spouse ○ Child 1 ○ Child 2 ○ Child 3 ○ Child 4 ○ Child 5 ○ Child 6 ○ Child 7 ○ Child 8

WITH LIBERTY BASE POLICY ○ **R-LIB25** ○ **R-LIB50**

WITH FREEDOM BASE POLICY ○ **R-LIB25** ○ **R-LIB50**

Premium $ [ ], [ ][ ][ ]. [ ][ ]

OPTIONAL LIFE INSURANCE

LIFE	LIFE FACE AMOUNT	LIFE PREMIUM
○ **Proposed Insured** [○ Term Life (18-63) ○ Whole Life (18-63) ○ 20 Year Life (18-63)]	$,	$, .
○ **Spouse** [○ Term Life (18-63) ○ Whole Life (18-63) ○ 20 Year Life (18-63)]	$,	$, .
Child Term Rider [○ $5,000 ○ $10,000]		

Total Collected with Application $, .

Total Premium $, .

PROPOSED INSURED

First Name | M.I. | Height (ft. in.)

Last Name | ○ Male ○ Female | Weight (lbs.)

Address

City | State | Zip Code | Age

Birth State | Date of Birth (mm-dd-yyyy) - - | SS # - -

E-mail Address

I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Proposed Insured's Occupation

Proposed Insured's Beneficiary | Beneficiary Relationship

Beneficiary for Spouse (and children) will be Proposed Insured unless notice is given to the Liberty National Life Insurance Company Home Office.

Spouse
First Name | M.I. | ○ Male ○ Female | Height (ft. in.) | Weight (lbs.)

Last Name

SS # - -

I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Birth State | Age | Date of Birth (mm-dd-yyyy) - -

Occupation

Child 1
First Name | M.I. | ○ Male ○ Female | Height (ft. in.) | Weight (lbs.)

Last Name

Age | Date of Birth (mm-dd-yyyy) - -

I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Child 2
First Name | M.I. | ○ Male ○ Female | Height (ft. in.)
Last Name | Weight (lbs.)
Age | Date of Birth (mm-dd-yyyy) – – | I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Child 3
First Name | M.I. | ○ Male ○ Female | Height (ft. in.)
Last Name | Weight (lbs.)
Age | Date of Birth (mm-dd-yyyy) – – | I, the agent, have personally seen this person. ○ **Yes** ○ **No**

	PROPOSED INSURED YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO
1. During the past 90 days, except for minor illness of less than one (1) week or pregnancy, has any illness, injury or health related problem prevented the Proposed Insured or any Family Member from working full time at his/her regular occupation or performing the normal activities of a person of the same age?	○○	○○	○○	○○	○○
2. Has the Proposed Insured or any Family Member **EVER** been treated for, diagnosed, or tested positive as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or ever tested positive for antibodies for the AIDS (HIV) virus?	○○	○○	○○	○○	○○
3. Has the Proposed Insured or any Family Member **EVER** had:					
a. Any disease or disorder of the heart or circulatory system including but not limited to heart attack or stroke; high blood pressure?	○○	○○	○○	○○	○○
b. Any disease or disorder of the eye, ear, nose, throat, lung, breast or reproductive organs?	○○	○○	○○	○○	○○
c. Any disease or disorder of the rectum, kidney, prostate, stomach, intestine, gall bladder, urinary bladder, liver or connective tissue; Lupus, collagen disease; pancreas, pituitary or adrenal gland?	○○	○○	○○	○○	○○
d. Any disease or disorder of the brain (including but not limited to retardation, dementia or Alzheimer's), mental or nervous system (including but not limited to seizures or convulsions), back or spine; paralysis or arthritis?	○○	○○	○○	○○	○○
e. Any cancer, tumor, cyst, hernia, goiter, diabetes, blood disorders including but not limited to anemia or spleen disorder?	○○	○○	○○	○○	○○
f. Any internal or skin cancer, melanoma, malignant growth, leukemia, Hodgkins disease or premalignant lesions?	○○	○○	○○	○○	○○
4. During the past three (3) years, has the Proposed Insured or any Family Member:					
a. Had his/her driver's license suspended or revoked because of a moving violation or been arrested for driving under the influence of alcohol or drugs?	○○	○○	○○	○○	○○
b. Received treatment for alcohol abuse or been advised by a physician to reduce alcohol consumption?	○○	○○	○○	○○	○○
c. Used or received treatment or consultation for heroin, cocaine or other similar agent or narcotic drug?	○○	○○	○○	○○	○○
5. Does the Proposed Insured or any Family Member participate in any hazardous sports or avocations? No benefits will be provided for loss due to such participation.	○○	○○	○○	○○	○○
6. During the past five (5) years, has the Proposed Insured or any Family Member:					
a. Had any medical or surgical advice, treatment or operations or been advised to have medical or diagnostic test(s), procedure(s) or surgery that has not yet been performed, or is awaiting medical test results?	○○	○○	○○	○○	○○
b. Been confined in a hospital?	○○	○○	○○	○○	○○
7. During the past two (2) years, has the Proposed Insured or any Family Member:					
a. Had a cesarean section, miscarriage or serious complications of a previous pregnancy?	○○	○○	○○	○○	○○
b. Been hospitalized 3 or more times?	○○	○○	○○	○○	○○
c. Received any disability benefits?	○○	○○	○○	○○	○○

APPLICATION FOR INSURANCE * LIBERTY NATIONAL LIFE INSURANCE COMPANY
A LEGAL RESERVE STOCK CO. * ADMINISTRATIVE OFFICE: MCKINNEY, TX

ARKANSAS/LOUISIANA

	PROPOSED INSURED YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO
8. Does the Proposed Insured or any Family Member have any existing (or pending application for) health insurance? If **"YES"** list coverage type _____	○○	○○	○○	○○	○○
9. Does the Proposed Insured or any Family Member intend to replace or change any existing health insurance? If **"YES"** a replacement notice must be completed and signed.	○○	○○	○○	○○	○○
10. Have you received an outline of coverage?	○○	○○			
If Optional Life coverage is chosen, please answer questions 11 thru 13:					
11. Has the Proposed Insured or Spouse used tobacco in any form within the past 12 months?	○○	○○			
12. Does the Proposed Insured or Spouse have any existing life insurance policies or annuity contracts?	○○	○○			
13. Will the life insurance being applied for replace or change any existing life insurance policies or annuity contracts? If **"YES"** a replacement notice must be completed and signed.	○○	○○			

If the Proposed Insured or any Family Member answered "Yes" to any of questions 1 -7, provide details below for each "Yes" answer.

* In column below list "**P** " for Proposed Insured, "**S**" for Spouse, "**C1**" for Child 1, "**C2**" for Child 2 and "**C3**" for Child 3.

*	Dates	Illness/Injury	Operation?	Name/Address/Telephone of Doctors & Hospitals	Complete Recovery?

AGREEMENT: I hereby apply to Liberty National Life Insurance Company ("Company") for a policy to be issued in reliance on my written answers to all questions. The applicant(s) represent(s) to the Company that the agent asked each and every question that appears on the application and that all the answers are true, correct and complete. I agree the policy shall not be effective unless it has actually been issued by the Company. I acknowledge that no agent has the authority to make, alter, modify or discharge any policy or any of its provisions for or on behalf of the Company; nor is the Company bound by any statement or representation made to any agent unless the statement or representation is included in this application.

I authorize the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to Liberty National Life Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to the MIB Inc., reinsuring companies or other persons or organization performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a copy of this authorization is to be acceptable. This authorization will remain in effect for a period of 24 months from the date signed. I understand that I may request a copy of this authorization. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734]. Information for consumers about MIB may be obtained on its website at www.mib.com.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To the best of your knowledge as soliciting agent, is the insurance applied for intended to replace any existing life, annuity or health insurance policies or contracts? ○ **Yes** ○ **No**

If "YES" a replacement notice must be completed and signed.

Date Application Signed (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐

State ☐☐

Signed _____
Agent's Signature

Last Name ☐☐☐☐☐ Agent No. ☐☐☐☐☐☐

Print First 5 Letters of Agent's Last Name

Signed _____
Applicant (Proposed Insured)

Signed _____
Applicant (If other than the Proposed Insured)

SEND POLICY TO: ○ Agent ○ Insured (The Policy will be sent to Insured unless otherwise instructed.)

APPLICATION FOR INSURANCE * LIBERTY NATIONAL LIFE INSURANCE COMPANY
A LEGAL RESERVE STOCK COMPANY

ARKANSAS

Requested Effective Date (mm-dd-yyyy)
[ ][ ] - [ ][ ] - 2 0 [ ][ ]

Payment Mode ○ Monthly ○ Semi-Annual ○ Quarterly ○ Annual

Payment Type ○ Bank Draft ○ Direct

Draft Day (01 to 28 only) [ ][ ]

BASE PLAN

Foundation Signature Series™

○ Proposed Insured ○ Child 1 ○ Child 2 ○ Child 3 ○ Child 4 ○ Child 5 ○ Child 6 ○ Child 7 ○ Child 8

○ Spouse

Maximum Annual Benefit

○ $10,000 ○ $4,000
○ $7,500 ○ $3,000
○ $7,000 ○ $2,500
○ $6,000 ○ $2,000
○ $5,000

Premium
$ [ ], [ ][ ][ ] . [ ][ ]
○ Additional Premium Included

OPTIONAL RIDER

Hospital Outpatient Benefit *

○ Proposed Insured ○ Child 1 ○ Child 2 ○ Child 3 ○ Child 4 ○ Child 5 ○ Child 6 ○ Child 7 ○ Child 8

○ Spouse

Premium
$ [ ], [ ][ ][ ] . [ ][ ]

* This rider does not increase the Maximum Annual Benefit.

OPTIONAL LIFE INSURANCE

		Life Face Amount	Premium
Life			
○ Proposed Insured	○ 10 Yr. Term (18-63) ○ Whole Life (18-63)	$ [ ][ ], [ ][ ][ ]	$ [ ], [ ][ ][ ] . [ ][ ]
○ Spouse	○ 10 Yr. Term (18-63) ○ Whole Life (18-63)	$ [ ][ ], [ ][ ][ ]	$ [ ], [ ][ ][ ] . [ ][ ]
Child Term Rider	○ $10,000 ○ $ 5,000		

Total Premium $ [ ], [ ][ ][ ] . [ ][ ]

Total Collected with Application $ [ ][ ], [ ][ ][ ] . [ ][ ]

PROPOSED INSURED

First Name | M.I. | Height (ft. in.)

Last Name | ○ Male ○ Female | Weight (lbs.)

Address

City | State | Zip Code | Age

Birth State | Date of Birth (mm-dd-yyyy) - - | SS # - -

E-mail Address

I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Proposed Insured's Occupation

Proposed Insured's Beneficiary | Beneficiary Relationship

Beneficiary for Spouse (and children) will be Proposed Insured unless notice is given to Liberty National Life Insurance Company's Home Office.

Spouse
First Name | M.I. | ○ Male ○ Female | Height (ft. in.) | Weight (lbs.)

Last Name

Age | Birth State | Date of Birth (mm-dd-yyyy) - - | I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Occupation

Child 1
First Name | M.I. | ○ Male ○ Female | Height (ft. in.) | Weight (lbs.)

Last Name

Age | Date of Birth (mm-dd-yyyy) - - | I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Child 2
First Name | M.I. | ○ Male ○ Female | Height (ft. in.) | Weight (lbs.)

Last Name

Age | Date of Birth (mm-dd-yyyy) - - | I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Child 3
First Name | M.I. | ○ Male ○ Female | Height (ft. in.) | Weight (lbs.)

Last Name

Age | Date of Birth (mm-dd-yyyy) - - | I, the agent, have personally seen this person. ○ **Yes** ○ **No**

APPLICATION FOR INSURANCE * LIBERTY NATIONAL LIFE INSURANCE COMPANY
A LEGAL RESERVE STOCK COMPANY

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IF THE ANSWER TO QUESTION 1 IS "YES" THEN CONTINUE. IF THE ANSWER IS "NO" THE PROPOSED INSURED IS NOT ELIGIBLE FOR COVERAGE.

	INSURED YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO
1. Does the Proposed Insured or a Family Member have a Major Medical Policy or other comprehensive health coverage in force (or pending application)? Please list company,policy number and effective date (if available). _____	○○	○○	○○	○○	○○
2. During the past 90 days, except for minor illness of one (1) week or pregnancy, has any illness, injury or health related problem prevented the Proposed Insured or any Family Member from working full time at his/her regular occupation or performing the normal activities of a person of the same age?	○○	○○	○○	○○	○○
3. Has the Proposed Insured or any Family Member **EVER** been treated for, diagnosed, or tested positive as having Acquired Immune Deficiency Syndrome(AIDS) or AIDS Related Complex (ARC), or ever tested positive for antibodies for the AIDS (HIV) virus?	○○	○○	○○	○○	○○
4. Has the Proposed Insured or any Family Member **EVER** had:					
a. a disease or disorder of the heart or circulatory system including heart attack or stroke; high blood pressure?	○○	○○	○○	○○	○○
b. a disease or disorder of the eye, ear, nose, throat, lung, breast or reproductive organs?	○○	○○	○○	○○	○○
c. a disease or disorder of the rectum, kidney, prostate, stomach, intestine, gall bladder, urinary bladder, liver, connective tissue, lupus, collagen disease, pancreas, pituitary or adrenal gland?	○○	○○	○○	○○	○○
d. a disease or disorder of the brain (including retardation, dementia or Alzheimer's), mental or nervous system (including seizures or convulsions), back or spine, paralysis or arthritis?	○○	○○	○○	○○	○○
e. cancer, tumor, diabetes, blood disorders including anemia or spleen disorder?	○○	○○	○○	○○	○○
f. had his/her driver's license suspended or revoked because of a moving violation or been arrested for driving under the influence of alcohol or drugs?	○○	○○	○○	○○	○○
g. received treatment for alcohol abuse or been advised by a physician to reduce alcohol consumption?	○○	○○	○○	○○	○○
h. used or received treatment or consultation for heroin, cocaine or other similar agent or narcotic drug?	○○	○○	○○	○○	○○
5. During the past five (5) years, has the Proposed Insured or any Family Member:					
a. Had any medical or surgical advice, treatment or operations or been advised to have medical or diagnostic test(s), procedure(s), or surgery that has not yet been performed, or is awaiting medical test results?	○○	○○	○○	○○	○○
b. Been confined in a hospital?	○○	○○	○○	○○	○○
6. During the past two (2) years, has the Proposed Insured or any Family Member:					
a. Had a cesarean section, miscarriage or serious complications of a previous pregnancy?	○○	○○	○○	○○	○○
b. Been hospitalized 3 or more times?	○○	○○	○○	○○	○○
c. Received any disability benefits?	○○	○○	○○	○○	○○
7. Does the Proposed Insured or any Family Member participate in any hazardous sports or avocations? No benefits will be provided for loss due to such participation.	○○	○○	○○	○○	○○
8. Does the Proposed Insured or any Family Member have any existing (or pending application for) health insurance? If **"YES"**, list coverage type _____	○○	○○	○○	○○	○○
9. Does the Proposed Insured or any Family Member intend to replace or change any existing health insurance? If **"YES"** a replacement notice must be completed and signed.	○○	○○	○○	○○	○○
10. Have you received an outline of coverage?	○○	○○			
If Optional Life coverage is chosen, please answer the following questions.					
11. Has the Proposed Insured or Spouse used tobacco in any form within the past 12 months?	○○	○○			
12. Does the Proposed Insured or Spouse have any existing life insurance policies or annuity contract?	○○	○○			
13. Will the life insurance being applied for replace or change any existing life insurance or annuity contracts? If **"YES"** a replacement notice must be completed and signed.	○○	○○			

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If any Proposed Insured or any Family Member answered "Yes" to any of questions 2 - 7, provide details below for each "Yes" answer.

* In column below list "**I** " for Insured, "**S**" for Spouse, "**C1**" for Child 1, "**C2**" for Child 2 and "**C3**" for Child 3.

*	Dates	Illness/Injury	Operation?	Name/Address/Telephone of Doctors & Hospitals	Complete Recovery?

AGREEMENT: I hereby apply to Liberty National Life Insurance Company ("Company") for a policy to be issued in reliance on my written answers to all questions. The applicant(s) represent(s) to the Company that the agent asked each and every question that appears on the application and that all the answers are true, correct and complete. I agree the policy shall not be effective unless it has actually been issued by the Company. I acknowledge that no agent has the authority to make, alter, modify or discharge any policy or any of its provisions for or on behalf of the Company; nor is the Company bound by any statement or representation made to any agent unless the statement or representation is included in this application.

I authorize the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to the MIB Inc., reinsuring companies or other persons or organization performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a copy of this authorization is to be acceptable. This authorization will remain in effect for a period of 24 months from the date signed. I understand that I may request a copy of this authorization. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits application for insurance or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

To the best of your knowledge as soliciting agent, is the insurance applied for intended to replace any existing life, annuity or health insurance policies or contracts? ○ **Yes** ○ **No**

If "YES" a replacement notice must be completed and signed.

Date Application Signed (mm-dd-yyyy) ____ - ____ - ____

State ____

Signed _____
Agent's Signature

Proposed Insured

Last Name _____ Agent No. _____

Signed _____

Print First 5 Letters of Agent's Last Name

Applicant (If other than the Proposed Insured)

LMGAPB(03) **SEND POLICY TO:** ○ Agent ○ Insured (The Policy will be sent to Insured unless otherwise instructed.)

"Automatic" Payment Plan / Bank Draft

Initials of Primary Insured _____

LIBERTY NATIONAL LIFE INSURANCE COMPANY

P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085
A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

TERMINAL ILLNESS ACCELERATED BENEFIT DISCLOSURE AND ACKNOWLEDGEMENT

The contract you have applied for contains a Terminal Illness Accelerated Benefit rider. We are required to provide you with this disclosure and obtain your signature, acknowledging your receipt and review of this document.

The Terminal Illness Accelerated Benefit rider on this contract allows the Insured to receive a portion of the contract's Death Benefit upon our receiving due proof that the Insured has a Terminal Illness.

DEFINITION OF TERMINAL ILLNESS: The Insured has been diagnosed with a noncorrectable medical condition that, with reasonable medical certainty, will result in the Insured's death within twelve (12) months from the date on which this benefit is requested.

AMOUNT OF BENEFIT: The amount of the Accelerated Benefit will be equal to 50% of the Death Benefit less 50% of any outstanding policy loan and loan interest.

"SAMPLE DEMONSTRATION:" The calculation of the Accelerated Benefit Amount and the effects on the remaining contract values are shown in the "sample demonstration" below:

CONTRACT DEATH BENEFIT:	**$5,000.00**
CASH VALUE:	**1,000.00**
POLICY LOAN:	**500.00**

ACCELERATED BENEFIT AMOUNT CALCULATION:

$ 5,000 X .50 =	**$2,500.00**	**Gross Amount**
$ 500 X .50 =	**- 250.00**	**Policy Loan**
	$2,250.00	**Amount Payable**

CONTRACT VALUES AFTER ACCELERATED BENEFIT PAYMENT:

$ 5,000 - 2,500	**$ 2,500.00**	**Death Benefit**
$ 1,000 - (.50 x 1,000) =	**500.00**	**Cash Value**
$ 500 - 250 =	**250.00**	**Policy Loan**

THIS FORM IS NOT A CONTRACT. IT IS INTENDED ONLY AS A SUMMARY OF THE RIDER PROVISIONS SHOWN. IN ALL CASES, CONSULT YOUR RIDER FOR FULL DETAILS AND RESTRICTIONS.

ANY ACCELERATED BENEFIT PAID UNDER THIS CONTRACT MAY BE TAXABLE. A PERSONAL TAX ADVISOR SHOULD BE CONSULTED.

PAYMENT OF ANY ACCELERATED BENEFIT MAY ALSO ADVERSELY AFFECT THE RECIPIENT'S ELIGIBILITY FOR MEDICAID AND OTHER GOVERNMENT BENEFITS OR ENTITLEMENT.

I hereby acknowledge receipt of this disclosure form as evidenced by my signature below.

_____ _____
Signature of Applicant **Date**

_____ _____
Signature of Agent **Date**

LABRD1

Liberty National
Life Insurance Company
P.O. Box 8080
McKinney, Texas 75070-8080

Liberty National
Life Insurance Company

PRELIMINARY TERMINAL ILLNESS ACCELERATED BENEFIT PAYMENT DISCLOSURE

The Insured of this contract has requested payment of the Accelerated Benefit.

The information below indicates the potential Accelerated Benefit amount as well as the effect on other contract values if the Accelerated Benefit amount is paid.

Policy Number: [SPECIMEN]
Insured: [JOHN DOE]
Issue Age: [35]

ACCELERATED BENEFIT AMOUNT: [$2,500.00]
CALCULATION DATE: [9/18/12]

Contract Values Prior to Accelerated Benefit Payment		Contract Values After Accelerated Benefit Payment	
Death Benefit:	[$5,000.00]	Death Benefit:	[$2,500.00]
Cash Value:	[0]	Cash Value:	[0]
Policy Loan:	[0]	Policy Loan:	[0]

ANY ACCELERATED BENEFIT PAID UNDER THIS CONTRACT MAY BE TAXABLE. A PERSONAL TAX ADVISOR SHOULD BE CONSULTED.

PAYMENT OF ANY ACCELERATED BENEFIT MAY ALSO ADVERSELY AFFECT THE RECIPIENT'S ELIGIBILITY FOR MEDICAID AND OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS.